Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 05/21/01.
   b. The request was received on 04/02/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. TWCC 66 forms
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. TWCC 66 form
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 06/28/02. The Respondent did not submit a response to the request. The "No Additional Information Received" sheet is reflected in Exhibit II of the Commission's case file. The carrier's initial response, date stamped 03/28/02, is included in the case file and will be reviewed.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/12/02
   "…(Claimant) has chosen (Requestor) under contract as her pharmaceutical service. Average Wholesale prices are determined monthly by Medispan and we computed fair and reasonable fees for the medications….(Carrier) has reduced are [sic] bills with the explanation –PPO Reduction. I would like to stress the fact that (Requestor) has no contract with (Carrier)…We are a pharmaceutical service and the patient is contracted with us. The pharmacy that (Carrier) is stating they have a contract with has already been

paid for their services by us. We billed pharmaceutical charges under our tax ID number and should be paid under that…. (Carrier) may not reduce our bills based on a contract that is non-existent…."

2. Respondent: Letter dated 03/05/02
"…(Requestor) is a billing service per…at that company. According to the bill, the prescriptions were filled at …Pharmacy. The NABP number on the bill is 4598403, which comes back to …Pharmacy. In 1996, …Pharmacy signed a PPO contract with…Corporation….It is our understanding that if the dispensing pharmacy has a contract, then the contract should be honored even through the third party billing service….(Pharmacy) signed a contract with…, when…received the billing, it was paid according to the contract."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/21/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $178.57; the amount paid is $98.13; the amount in dispute is $80.44.

3. The carrier denied the billed services by code, "C – NEGOTIATED CONTRACT".

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
05/21/01	Etodolac 400mg Amitriptyline 10mg Hydrocodone APAP 7.5 Carisoprodol 350mg	$98.63 $14.75 $22.12 $43.07	$55.83 $7.20 $11.48 $23.62	C C C C	No Mar	TWCC Rule 133.304 (c)	TWCC Rule 13.304 (c) states, "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's actions(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description for the reason for the reduction or denial of payment does not satisfy the requirements of this section." The carrier denied the medications by "C _ NEGOTIATED CONTRACT", but failed to provide sufficient explanation of their denial as required by Rule 133.304 (c). Therefore, additional reimbursement is recommended in the amount of **$80.44.** (Billed $178.57 - $98.13 already paid = $80.44.)
Totals		$178.57	$98.13				The Requestor **is** entitled to reimbursement in the amount of **$80.44**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $80.44 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 28th day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm